Eating Disorders: A Case Study Analysis

An Honors Thesis (HONRS 499)

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Abstract

This paper displays eight cases involving the struggles of an eating disorder and an analysis of each case. Each case is described in moderate detail and gives some insights into how each person deals with their disordered eating behavior. The cases range from moderate to severe. They are all different in their own way, yet similar in many ways as well. The project was meant to be a learning experience for the author, who has also struggled with an eating disorder.

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Prelude

As we go through life as human beings, there are many obstacles we encounter in our quest for a happy, satisfying life. Though we are all created equal, each one of us is unique in our own way and we all have different views regarding what the ideal way of life involves. Though one person's ideal may involve being a world traveler and owning multiple houses in different countries, another person will be happier living alone in a one-bedroom apartment. I believe that we go through life trying to mold our lives to our own ideal. This may be a conscience or unconscious effort depending on the person. We all make choices in life and these choices reflect what our priorities are. Some one may think that their ideal way of life would be to be a brain surgeon, but if that person chooses not to go to medical school, the priority is clearly something different. On the other hand, some one may be happier pursuing a lower income career, but outside pressure from family or friends may push the priority towards becoming a brain surgeon.

Everyone, however, is their own person, and, whether it is influenced by an outside source or not, every choice they make is their own. We live in a world where we encounter obstacles every day. They range from trivial to life changing, but they are always there. How we deal with these obstacles contributes to defining us as individuals. A major hurdle for one person may be trivial to another and vice versa. Sometimes a major obstacle can have an impact on nearly every aspect of a person's life, and the path that his or her life is taking will change because of this. I am beginning to believe that everything happens for a reason, whether we know it at the time of the incident or not. I truly believe that there is a purpose for every obstacle and every way of dealing with the obstacle. This is one reason why everyone is different and why every one is unique in his

or her own way. I have faced many obstacles in my life; most of which have been fairly minor. My struggle with one of these obstacles has left a lasting impression on me, and impelled me to write about it.

When trying to decide what to do for my honors senior project, I had a few things in mind I wanted to incorporate into the project. As I have understood it, the "senior thesis" is supposed to reflect an area of interest and show how the student has grown as an honors student. I am a pre-dental major, so I first considered doing a research project in the biology department. I was very unsure, however, what I wanted to do research on. I also tried to think of some different things I could do involving dentistry. This idea was also unclear to me. However, another idea was in the back of my mind pushing its way forward. I've been struggling with an obstacle that has been a part of my life for many years. It has had a huge impact on me and has been something I've been dealing with in the shadows since I was young.

Since about age 11, I have been dealing with an eating disorder. It has undoubtedly been the biggest obstacle I have encountered in my life so far. It has been a struggle in the dark for me, and a battle that I had been fighting single handedly for over half of my life. Throughout middle school and high school, I kept this very much to myself. I was incredibly ashamed of what was happening, and I had myself convinced that I could deal with it on my own and that no one ever had to know about this obstacle in my life. It grew to become a bigger and bigger part of every day for me. Although outwardly this was not too apparent, the disorder was consuming me and making me hate the person that I was becoming. I had no control over it and didn't have the courage to ask for help. Most of my energy was going towards trying to beat this problem I was

having and I was not winning the battle. The best word I can think of to describe my thoughts is "intense." I was constantly trying and trying and trying to overcome this disorder. However, it seemed that the harder I tried the worse things got, and I just couldn't do anything about it. Sometimes I was just overwhelmed with this feeling of complete helplessness.

Going to college was kind of the beginning of my recovery. It was by no means all up hill. Things were up and down for me as far as good times and bad throughout my four years, I've had some major breakthroughs just recently. My first breakthrough was when I started going to counseling my second year during a pretty difficult time. However, I wasn't yet at the point that I was mentally ready to make significant changes. The next couple years were like a roller coaster as far as good times and bad, but toward the end of my fourth year things began to change for the better. It was like a light bulb lit up in my head telling me that this was an obstacle like anything else and how I chose to handle it was affecting my life. I had to force myself to realize that I was in control, and the only thing that was holding me back from striving for my ideal life was my own self. There was no one to blame but myself, and, in all actuality, there didn't need to be blame. I just needed to start doing what I had to to make myself happy.

At that point, I returned to counseling and even started group therapy. Slowly, my outlook began to change. I began to be more open and able to talk about what I was going through, which was the biggest help of all for me. This is the point at which I stand now. I am by no means recovered, but I am very far ahead of where I was even six months ago, and things continue to get better every day. I am starting to realize that life

is what you make out of it. Everyone is in charge of their own self, and whether they know it or not, they are the only ones who have the ability to make their selves happy.

I chose to do my senior project on the subject of eating disorders because it has impacted my life more than anything else has. This includes my family life, social life, life as an athlete, and definitely my education. Because it has had such a strong impact on me, and because the subject matter is so interesting to me, I have decided to take this opportunity to look more deeply into this disorder that has plagued millions of people around the world.

My primary goal for this project was to learn more about myself. I thought that one way I could do this was through looking at other cases involving eating disorders. What is interesting to me is to look at how different people have developed and dealt with different types of eating disorders that they have had. I have looked at many case studies and picked them apart to see what I could learn as far as the similarities and differences among cases and why each case developed in the first place. For a majority of the paper, I have analyzed each separate case and related the issues involved in each to both the information that I have found from other sources about eating disorders, and my own opinions about each case. I am mainly interested in the cause or origin of the problem, but I will also be discussing other information pertinent its persistence or anything interesting about the case in general.

Case #1

> Ms. C was a 23-year old single woman, who came to the hospital weighing 93 lb (height 69 in.). She had a long history of eating disorders, commencing at age 14 after she was raped on a date. Subsequently, she began to feel depressed, inadequate, and physically unattractive – feelings she attributed to being overweight. It was at that point, in early adolescence, that she began to eat more (to "fill up a loneliness and emptiness" inside of her) and to induce vomiting in order to control her weight. She experienced intermittent dysphoria throughout her adolescence, and, on one occasion, attempted suicide. Her parents were oblivious of her problems until she had become markedly underweight and confided her self-induced vomiting; at their insistence, she entered treatment. Her bulimic behaviors persisted despite individual and group psychotherapy and pharmacotherapy with a variety of tricyclic antidepressants and monoamine oxidase inhibitors. At age 23, she was hospitalized with an admission weight of 92 lb, and was diagnosed as having anorexia nervosa. During the course of her hospitalization, she became more depressed and actively suicidal. She failed to respond to adequate inpatient trials of desipramine (200mg), nortriptyline (200mg), and trazodone (600mg), and, after attempting suicide, was referred for ECT as a lifesaving alternative. The patient underwent a course of 16 bilateral ECT treatments with no appreciable change in her attitude about eating, her food intake, or her depressive symptoms. Because of her failure to respond and because of treatment-related cognitive deficits, ECT was abandoned. She remained in hospital and was then treated with a combination of desipramine (300mg/day), trazodone (400mg/day), and perphenazine (4mg t.i.d). Continuing in group and individual therapy, she eventually increased her weight to around 100 lb. One year after discharge, she continued to express a profoundly distorted body image, confided a morbid fear of becoming fat, and practiced multiple food rituals, including binging and purging and chewing breakfast cereal for several hours each day and spitting it into

> small plastic bags. At 2 year follow-up, she had maintained her weight at about 100 lb, despite no significant change in her abnormal eating behaviors; though still depressed, she was no longer actively suicidal, an improvement she attributed to psychotherapy, which helped her "cope with" her suicidal urges. She was then treated with flouxetine (80 mg/day). Over a period of 12 weeks, the frequency of her binging and purging decreased, her weight increased to 115 lb, and her depression improved. She "fell in love" and developed an intense relationship with an man whom she subsequently married. She returned to college, graduated with high honors (in psychology), and at 3 year follow up, had maintained her improvement, both with respect to her eating disorder, depressive symptoms, and her relationship. (Ferguson, 1993, 198)

Discussion: This case notes quite directly that the eating disorder started after the young woman was raped on a date. This very traumatic experience was obviously a major cause of her disordered eating since the problems started immediately afterwards. There are many cases that I have looked at where something traumatic in a person's life causes the beginning of an eating disorder and it builds from there. Something like rape can have an immense impact on many aspects of a person's life from what they choose to wear to their entire outlook on life as a whole. This is such a negative occurrence that it is so difficult to keep from allowing oneself to feel the negative effects of it. I think that from rape there were probably a series of events that happened leading to disordered eating. First of all, the girl became depressed. This could very well lead to various mental or emotional problems including an eating disorder. She may have felt that something was taken from her such as her control over events in her life or her sense of safety and security. She needed to feel comfort from this loss and needed a way to cope. In this case there was more to the story. She began to feel inadequate and physically unattractive. Body dissatisfaction is a key risk factor for the development of an eating disorder (First, Gibbon, Skodol, Spitzer, Williams 1994). Because she was feeling unhappy with her appearance, this was the area that she was forced to believe she needed to change. However she felt lonely and empty inside. The comfort of food must have seemed like the only way for her to alleviate her feelings of loneliness. But because of

her inclination to feel unhappy with her appearance, she compensated by inducing vomiting to control her weight.

This girl became so depressed that on many occasions she was actively suicidal. Again, this is common among many cases that I've looked at. I think of it as a vicious circle. First of all, the girl is depressed and lonely. To make up for this she eats unusually large amounts of food. However, the guilt and disgust of her actions cause her to compensate for this and "get rid of" the food she just ate. The food is now gone, but the feeling of guilt or shame remains which circles back to her depressed feeling she initially had. The cycle starts over from there.

The fact that her parents were oblivious to the problem she was facing could mean a few different things. It could be that her parents don't want to believe that there is a problem, which I have not seen to be true in very many cases. It could be that they aren't around much and just don't notice anything unusual. In most cases that I've seen, however, a bulimic person is very secretive about his or her actions. There is a lot of shame that goes along with the disorder and keeping everything in the dark is usually the favorable way of dealing with the guilt and shame. This also, can turn into a vicious circle. Hiding something that is shameful will lead to guilt that will circle back to the feeling of needing to hide.

This patient was also diagnosed with anorexia nervosa after entering the hospital at a weight of 92 lb. I have found this to be common among many cases involving eating disorders. It's usually not just one disorder, but a mixture of a couple. The despair that came about from feeling the need to binge and purge may have initiated the motivation to severely restrict food intake. This has been shown to relieve the guilt of the binge-purge

cycle and make the person feel much better about his or her self. In spite of this, restrictive dieting is another major risk factor for the development of an eating disorder (First, Gibbon, Skodol, Spitzer, Williams 1994). Obviously, a person needs to eat to maintain physical health. The body will fight restrictive dieting because it has such harmful effects. The person will become so hungry that all he or she can think about is food. This is the body's way of struggling to get the person to eat. There are also other effects such as headaches, stomach pains, dizziness, nausea, fatigue, and many other signs of physical hunger. Since these symptoms are so difficult to fight, the end result if often a binge. The person holds out as long as possible on the restrictive diet but can't maintain that diet for a long period of time. The binge-purge behaviors recur until more motivation is built up to begin anorexic/starvation behaviors again. This could be seen as another vicious cycle.

Fortunately, this case has a happy ending. With group and individual therapy, Ms. C began to improve her condition and eating behaviors became more normal. Her weight increased to a healthy level and she became less depressed. She then became involved in a relationship, got married, went back to college where she graduated with honors with a degree in psychology. This is an incredible success story that should inspire anyone fighting an eating disorder because this girl went from rock bottom to a complete success. I think that her accomplishments also show that she does have an overachieving, perfectionist personality that was masked for so many years by her eating disorder. This type of personality is common for these disorders as will be apparent in other cases.

Case #2

Nadia, a 28-year-old, single woman, the daughter of an affluent and distinguished French family, was an accomplished artist and musician, fluent in 4 languages, who seemed destined to occupy a prominent place in society. However, at the time of Janet's case report, she had lived for 5 years sequestered in a small apartment, seeing virtually no one, leaving her home only at times of the most dire necessity, and then only at night.

From the age of 4, she had manifested bizarre obsessive-compulsive symptoms. By the age of 10, her obsessions began to focus particularly on her body: she became obsessed with the ugliness of her hands, her feet, her hips, and her hair. The onset of puberty further exacerbated this pathology; the development of pubic hair and enlargement of breasts horrified her. She developed a vast repertoire of obsessional rituals to prevent herself from growing any further.

Nadia would promise herself to begin the same prayer 5 times or 10 times, or to jump 5 times on one foot. Then, recognizing this behavior as absurd, she would resolve not to perform such acts, only to be thrown into torments as to which course – to act or not to act – was superior.

At about the age of 15 or 16, she decided no to eat so as not to grow any larger. By the age of 18, shortly after the death of her mother, she had reduced her weight on a bizarre daily diet: 2 bowls of clear bouillon, one egg yolk, a spoonful of vinegar, and a cup of tea with the juice of an entire lemon added.

A 6-month hospitalization and re-feeding program produced only temporary improvement; her anorexic behavior was quickly resumed. She described it as follows:

'Sometimes I spent hours thinking about food because I was so hungry. I swallowed my saliva, I chewed my handkerchief, I rolled on the ground in my desperate desire to eat. I searched in books for descriptions of great banquets, and tried to trick my hunger by imagining that I was tasting all of those wonderful things. I was truly famished, but save for periodic lapses into eating biscuits, I knew that I had a lot of courage.'

It is not clear from the case report whether or not Nadia suffered from major depression by modern criteria. She experienced severe depression at times, which may have been accompanied by sleep disorder, psychomotor agitation or retardation, impaired concentration, or suicidal thoughts.

There is no clear evidence that Nadia meets the DSM-III criteria for a personality disorder. Nadia's eating disorder lacked features of hysteria. Nadia's family history contained no frank cases of major psychiatric disorder, but her mother and sisters are all described as showing obsessive-compulsive traits. Her treatment was to be separated from her family and re-establishing a more normal eating pattern forsaking some of her compulsive rituals. (Hudson, Mialet, Pope Jr., 1985, 739)

Discussion: The very first thing that stood out to me when I started to read this case was the fact that Nadia was from a distinguished family. To me, that just screamed out "expectations." Nadia was already part of a well-known and most likely successful family, which can promote certain pressures to excel in life. For many, these are positive pressures that impel people to work hard to accomplish their goals. For others it is a negative stressor that can have damaging effects. The case informs us that Nadia began to have obsessive-compulsive symptoms as early as age 4. This type of behavior is seen frequently in eating disorder cases. It causes individuals to get caught up in even the most trivial situations because they obsess over the situation to the point where that is all

they can think about and the consequential actions are the compulsions that are typically uncontrolled. At the age of 10, Nadia began to obsess over her body. She thought her hands and feet were ugly along with her hair and hips. It's difficult to know exactly how this body dissatisfaction originated. The case doesn't give a whole lot of clues as far as what caused this to develop. Studies have found that women or girls who are at the greatest risk for eating disorders are those who have accepted and internalized most deeply the sociocultural mores about thinness and attractiveness. Along with this, some subcultures are more prone to acquire this type of mentality. A major subculture known for this is one of higher socioeconomic status (Rodin 248). This definitely describes Nadia's family. She was from an "affluent and distinguished" family, which can put pressure on young children.

This poor body image along with an obsessive-compulsive attitude lead her to the problems with eating that she began to have soon after the onset of puberty. Her obsession migrated toward weight and food. It began to be all she could think about and her obsessive-compulsive behavior prompted her to develop superstitions regarding her food intake. Some of the rituals she engaged herself in would seem ridiculous to most people, but she was so caught up in what she was obsessing over that these rituals seemed to her like her only way to handle what she was up against (her desire "not to grow"). It seems like she got trapped into her eating disorder and didn't know any other way to deal with it.

Another point worth looking at was that her problems with eating started at the onset of puberty. She was disgusted with what was happening to her body. This time in a girl's life is a very common breeding ground for an eating disorder. This is the time

when the female body begins to develop more adipose (fat) tissue especially in the area of the hips, thighs, and breasts (First, Gibbon, Skodol, Spitzer, Williams 1994). For many girls, it is an awkward time in their lives, but for others it goes above and beyond simple awkwardness. A feeling of body dissatisfaction can develop which prompts girls to feel that it is necessary to resist the changes that inevitably going to take place (Rodin, Silberstein, Striegel-Moore 1986). Some feel that they will just keep getting bigger and bigger, which scares them into attempting to control their body's destiny. This is what seemed to happen to Nadia. She was disgusted with her body and had to do something about it. She went on a very restrictive diet to compensate.

As can be seen in other cases, there is a traumatic event that seemed to induce the strict diet she engaged in. Her mother died when she was 18 years old. While she was already having problems with body image and weight before this point, her problems appeared to escalate after her mother's death. The case study doesn't mention any of her feelings about the death of her mother, so it is unclear to me what was going on in her head at that point. She could have been feeling a loss of control over events in her life and felt that by controlling her eating she would feel a better sense of control in general. This desire for control is a trait seen in many eating disordered individuals. Some feel that they have lost control in their lives and the only or easiest way to gain that back is to control their eating behaviors.

Another possibility for Nadia's reaction to her mother's death could be that, since she was from such a distinguished family, she was letting her mother down by being "large and ugly" as she thought she was. This may have provoked her to feel obligated to lose weight out of respect for her mother. Though I've seen this in other cases, I don't

think that this is the reason for Nadia's plunge into the strict diet. She seemed to do what she did because of how she felt about herself and not how she thought other people felt about her.

As was the situation in other cases, Nadia was not only anorexic, but she developed bulimia nervosa later down the road. She developed bulimic episodes where she would "devour everything she could find." Her binges were followed by terrible remorse throwing her into the vicious circle of compensation for this guilt. She seemed to be more inclined to starve herself than to engage in binge-purge behaviors, so clearly she was more anorexic than bulimic, but she did display both disorders.

Nadia was eventually successfully treated and began to develop normal eating habits. One more thing I will mention about this case is that both her mother and sisters showed signs of obsessive-compulsive disorder. It is true in many cases that I have looked at that a family history of mental illness increases the chance of the development of an eating disorder. This is definitely not true in all cases, but common enough to be a significant factor when analyzing case studies. It was true in the case of Nadia and her family.

Case #3

> Abby, age 42, had not had a food binge for over 2 years when she flew from Miami to Chicago to attend the wedding of her friend's daughter. Single, independent, and devoted to her work, Abby had just sold her first screenplay. She was pleased, but she was also experiencing the "postpartum" letdown that always occurred when she finished a major project.
> Despite knowing, from 2 years in Overeaters Anonymous (OA), that she needed to keep a safe distance from food, especially in emotionally hard times, Abby spent the entire day of the wedding rehearsal party in the company of food. She stood in her friend's kitchen for hours – cutting, chopping, sorting, arranging, and eventually picking at the food.
> When night and the guests came, the flurry of activity made it easy for Abby to disappear – physically and emotionally – into a binge. She started with a plate of what would have been an "abstinent" meal (an OA concept for whatever is included o one's meal plan): pasta salad, green salad, cold cuts, and a roll. Although the portions were generous, Abby wanted more. She pent the next 5 hours eating, at first trying to graze among the guests, but then, when shame set in, retreating to dark corners of the room to take frantic, stolen bites.

> Abby stuffed herself with crackers, cheeses, breads, chicken, turkey, pasta, and salads, but all that was a prelude to what she really wanted – sugar. She'd been waiting for the guests to leave the dining room, where the deserts were. When they finally did, she cut herself 2 pieces of cake, then 2 more, then ate directly from the serving tray, shoveling the food into her mouth. She reached for cookies, more cake, and cookies again. Heart racing, terrified of being discovered, Abby finally tore herself away and slipped into the terrace.
>
> By now, in what she thought of as a "food trance,: Abby piled her plate with bread, onto which she smeared some unidentifiable spread. Though the food tasted like mud, Abby kept eating. Soon other guests came out to the terrace, leaving Abby feeling she had to move again which she did, stepping into the kitchen – and the light. When Abby glanced down at her plate, she was horrified; ants were crawling all over it. Instead of reflexively spitting out the food, Abby, overcome by shame, could only swallow. Then her eyes began to search the debris on her plate for uncontaminated morsels. Witnessing her own madness, Abby began to cry. She flung the plate into the trash and ran to her room.
>
> That event marked the beginning of a 6-month relapse into binge eating – Abby's worst experience with bingeing since the problem began 15 years earlier. During the relapse, she binged on sugar foods and refined carbohydrates, returned to cigarette smoking to control the bingeing, and once again was driven to "get rid" of the calories by incessant exercise after each binge, walking 4 or 5 hours at a time, dragging her bicycle up and down 6 flights of stairs, and biking miles after dark in a dangerous city park. (First, Gibbon, Skodol, Spitzer, Williams, 1994, 40)

Discussion: Abby was diagnosed with the unusual Nonpurging Type of Bulimia Nervosa. Though this case does not describe anything earlier than the time of her relapse, there are still some very interesting details involved in this case. For instance, Abby was roughly 27 when the disorder began, which is well past the age of adolescence. The onset of her disorder is fairly atypical in this way. However, it is common that when the onset occurs past puberty, the disorder is more likely to be Binge Eating Disorder or, as was the case with Abby, Nonpurging Type of Bulimia. I am unsure why this is. It may be that as people age, they gain more of a sense of self that, while they still fell the guilt and shame of their actions, they don't feel the urgency to compensate as strictly as younger individuals do. Those who are going through adolescence are just beginning to get a grasp on who they are as people. The pressure to strive for the "ideal" is so strong that compensatory actions seem crucial. I am not, however, belittling the pain and suffering of post-adolescent eating disordered individuals. Everyone's thoughts and feelings are different in their own way.

Another aspect of this case that was interesting to me was the "tunnel vision" experienced by Abby as soon as she got into the eating mode. Her thoughts were unidirectional, and only one thing was on her mind – food. Everything else that was going on at the party was no longer of importance to her. Her mind seemed auto-programmed for a mission and nothing else mattered. It was described as a food trance and I think that that is the perfect way to describe what Abby was going through during the party. The definition of a trance according to www.deep-trance.com, is " the name given to any state of mind where that person has a narrow focus of attention." This can undoubtedly describe Abby's state of mind during the party. The narrow focus was food and food only. Though she was ashamed of what she was doing, she did not change her actions. With the mindset that she was experiencing at that time, the only thing she could change was who she was ashamed in front of. She thought she could offset her shame by avoiding people, but all this did was worsen her situation. She was hiding because of shame but the hiding itself brought upon more shame. She was no longer eating to enjoy the food, she was trying to "satisfy" herself as well as she could by forcing as much food as possible into her mouth while others were absent from the room.

This hiding not only brought about shame, but anxiety as well. She was ashamed of how much she felt she needed to eat, so she didn't want anyone to notice what she was doing. So, while she was in a room by herself, she felt the urgency to get as much down before anyone entered. The case described her feelings as being "terrified of being discovered." While she would have probably preferred the opposite, the desire to eat outweighed the desire to feel accepted at the party. She may also have felt some shame about her priorities, which leads to guilt, which leads to more desire to eat.

Though Abby had not binged 2 years prior to the party, that 1 incident sparked a relapse of her binging that lasted 6 months. I have noticed that many people struggling with eating disorders display an all-or-nothing mind set. An example would be the attitude that, "If it's not going to be perfect, then why should I try?" Abby was doing so well for 2 years. After the party she may have felt like she couldn't or didn't want to handle her disorder anymore, and she just gave into it. She didn't want to look at what had happened as a temporary set back that she could move on from. She was ashamed and embarrassed of what had happened and slipped back into her bad habits. It's difficult to say why this relapse occurred. If I were to guess, I would say that her recovery, which she was doing so well with, was a big struggle for her. This is very understandable because an eating disorder is so difficult to recover from. Her struggle most likely became a stressor in her life, and the situation was ok as long as she "kept a safe distance from food" in times of emotion and stress. I do think that that is a good idea, but food is always going to be everywhere – it's what we live off of as human beings, and avoiding it is impossible. Abby may have been doing well with her recovery, but avoiding the problem didn't do her much good in this case. I think that because of her all-or-nothing mentality, she figured she had ruined all of her hard work by losing control on that one occasion. Instead of picking herself back up and moving on, she surrendered to her eating disorder that she had been winning the battle with. It is good to know, however, that this binge period only lasted 6 months and Abby was able to get back on the right track after this.

Case #4

> Nancy is a 23-year-old woman from Arkansas. A letter she wrote to a research group is as follows: "Several years ago, in college, I started using laxatives to lose weight. I started with a few and increased the number as they became ineffective. After 2 years I was taking 250 – 300 pills at

one time. I would lose as much as 20 lb in 24 hours, and would be so dehydrated that I couldn't stand, and could barely talk. I ended up in the University infirmary several times with diagnoses of food poisoning severe gastrointestinal flu, etc., with bland diets and medications. I was released within a day or 2.

I would not eat for days, then would eat something, and overcome by guilt at eating, and hunger would eat, eat, eat. A girl on my dorm floor told me that she occasionally forced herself to vomit so that she wouldn't gain weight. I soon discovered that I could consume large amounts of food, vomit, and still lose weight. I lost 90 lb and my hair started coming out in handfuls. My teeth were also loose.

I never felt lovelier or more confident about my appearance. When I bent over, each rib and back vertebrae was outlined. The more I lost, the more I was afraid of getting fat. I exercised for hours each day to tone my figure from the weight fluctuations, and joined the university track team. I was subsequently forced to quit because one lap would make me dizzy, with cramps in my stomach and legs.

I came across an article on anorexia nervosa and it frightened me to the point where I forced myself to eat and digest healthy foods. I studied nutrition and gradually forced myself to accept a new attitude toward food – vitalizing – something needed for life. I eat all healthy foods and have not touched anything like pizza, pasta, pork, sweets, or anything fattening in 5 years.

It had been difficult for me to face people at school. I felt I would only be able to face people when I lost 'just a few more pounds.' Fat. I cannot stand it. This feeling is stronger and more desperate than any horror at what I am doing to myself. If I gain a few pounds I hate to leave the house and let people see me. Yet I am sad to see how I have pushed aside the friends, activities, and state of energized health that once rounded my life."

Nancy was a model but became too sick to pursue this further. The more she threw up in college, the longer it took and the more intense were the means. Her knees were calloused from time spent kneeling sick and she dreaded the gagging and pain from using ipecac or electrical cords she would use to induce vomiting. Her lips and fingers were bluish and cold. There were red spots over her eyes.

In her letter, Nancy mentioned that she was hopeful that her new-found honesty about her illness could bring her more help than humiliation. It seamed to her that she was being brutalized by some unrelenting force. She also said that she realized that there were "no demons, only me." (First, Gibbon, Skodol, Spitzer, Williams, 1994, 127)

Discussion: This is an extreme case of being completely overcome by the disorder. As far as Nancy was concerned, there was no priority other than weight loss. Nothing else mattered to her but that. This case displays just how secretive a bulimic can be because at the university infirmary, she was diagnosed with everything but the actual disorder that she was struggling with. On a college campus there are always people around everywhere, so keeping something that was such a huge part of her life a secret had to have been really difficult. There was the instance with her attempt to join the track team that didn't work out. Again, her mind was only set to weight loss. She had been running and running to lose weight. When this was combined with her binging and purging

behavior and laxative abuse, there was no way she could have had enough energy to be on the team and keep up with those that were eating normally.

This is also a clear example of how the obsessive-compulsive part of the disorder works. Nancy is truly obsessed with her weight. The tunnel-vision mind set had torn her away from everything else that was going (or could have been going on) in her life. From what was described about her personality in the case, it looked as if she could have been an incredibly talented girl. First of all, she was going to college – not a major accomplishment in and of itself, but it does tell us that she did care about her future and wanted to pursue her goals. Second, it appeared that she was a strong runner until she lost all of her energy due to her dieting and failure to digest any of the food she was eating. Being able to run as much as she did when she had nothing to fuel her body makes it clear that she would have been incredible if she had had the energy. It's sad to hear about the athletes who strive so wholeheartedly to be the best that they can be only to push themselves past the limit as far as their eating behaviors. Some athletes in appearance based sports literally starve for perfection, and end up cheating themselves out of being the incredible athletes they could be. The importance of body image and weight becomes overemphasized in their minds, and the desire to strive for the ideal body becomes more important that the desire to strive for excellence in the sport. These people destroy the ability they possess to excel in their sports. They just try too hard.

This overemphasis of appearance and weight could come from a few different places. It could come from the individual. Some athletes have the mind set that appearance and weight are truly the most important aspects of their sport. They want so badly to be good at what they do and controlling their eating to the point of severe

restriction is their best shot at doing this. It could come from coaches. There are some coaches out there that have this skewed view that the athletes who overemphasize weight have. Some coaches will go to the extreme of daily weigh ins and insulting comments such as telling the athlete that he/she is fat or that he/she won't get anywhere in the sport unless he/she loses 5 pounds or so. This overemphasis could also come from other sources such as pushy parents or simply the media. I think that usually it is a combination of sources that stimulates this overemphasis of weight and appearance. This is what builds its strength and causes it to become an issue.

Another factor other than the desire to be thin is the intense fear of becoming fat. For some people it seems like the worst thing in the world that could happen is for them to gain weight and become fat. In classes that I have taken, I have learned that there are many people who would rather die than become fat. This makes sense to think about because what anorexic and bulimic individuals are essentially doing is starving themselves to death. The absence of fat is a higher priority than life itself.

Another sign that she was a talented young woman was that she was obviously a very motivated and driven person. Anyone who could stick to the diet she was originally on, continue to take the laxatives, and persistently induce vomiting through all of the pain and suffering has to be extremely motivated. Though the motivation is in the wrong direction, Nancy is the type of person who knows what she wants (or at least thinks she does) and will pursue that at all costs. She wanted to be thin. She did everything within her power to get herself to where she wanted to be. Unfortunately all of this motivation, determination, and ambition went toward something that was slowly killing Nancy. I have often wondered what would happen if individuals with eating disorders took all of

the mental energy they put into the eating disorder, and geared it toward something positive. I believe that those individuals would be incredibly successful people. The amount of time and energy that feeds an eating disorder is so incredibly great. Channeling just a small part of this energy toward something positive would do wonders for the people who are at the point where nothing exists to them but their eating disorder. It takes a unique person to develop a serious eating disorder. I sometimes think of the word "passionate" when describing individuals with eating disorders. That word is usually used to describe something positive, but it means enthusiastic, obsessive, and fanatical. If this passion, that is strong enough to drive someone to cause his or herself as much damage as it does, was geared toward trying to live a happy life, these people would be on cloud nine throughout most of their lives. I am truly amazed at how far someone will go to maintain or increase his or her troubles with eating. Nancy was a good example of how caught up someone can get over these troubles.

Case # 5

> Eight-year-old Tim was referred by a pediatrician who asked for an emergency evaluation because of a serious weight loss during the past year for which the pediatrician could find no medical cause. Tim is extremely concerned about his weight and weighs himself daily. He complains that he is too fat and if he does not lose weight he cuts back on food. He has lost 10 pounds in the past year and still feels that he is too fat, though it is clear that he is underweight. In desperation, his parents have removed the scales from the house; as a result, Tim is keeping a record of the calories that he eats daily. He spends a lot of time on this, checking and rechecking that he has done it just right. In addition, Tim is described as being obsessed with cleanliness and neatness. Currently he has no friends because he refuses to visit them, feeling that their houses are "dirty"; he gets upset when another child touches him. He is always checking whether he is doing things the way they "should" be done. He becomes very agitated and anxious about this. He has to get up at least two hours before leaving for school each day in order to give himself time to get ready. Recently, he woke up at 1:30am to prepare for school. (First, Gibbon, Skodol, Spitzer, Williams, 1994, 367)

Discussion: This case was so interesting to me because of its unusualness. For one thing, Tim is male which, although eating disorders do develop occasionally in men, is atypical for an eating disorder. The point that caught my attention, however, was that Tim is so very young. Its difficult for me to even imagine what could be going through

this kid's head at such a young age. He's counting calories at an age that most children don't even know what a calorie is. He also has many other characteristics that most children his age don't give a second (if even a first) thought to.

Two characteristics that Tim shares with other individuals having Anorexia Nervosa are his fear of becoming fat and feeling fat even when obviously underweight. Again, for an 8-year-old boy this is extremely out of the ordinary. It makes me wonder why he started to feel this way in the first place. The case does not describe what his parents are like. They may be avid dieters and their attitudes and actions rubbed off on their child. This is a commonality among some eating disordered individuals (Lieberman 1989). Parents who diet or are very focused on their weight tend to send the message to their children that to be accepted, they must be thin. The children feel that they must live up to their parents expectations of having a thin body, even though those expectations may have been something the children just thought were a reality. Some think that they won't make their parents proud unless they too diet and try to lose weight. This doesn't seem like a reality in this case, because the parents are actively trying to stop their son's behavior.

Tim may have picked up his beliefs from the media, which is a possibility that has gotten much attention recently. The average American is exposed to 1500 ads per day (Kilbourne 395). The diet industry had tripled in the last 10 years and we are continually taught to hate our bodies. There is beginning to be such an emphasis on weight in this country along with others. This may have been where Tim got his ideas about needing to lose weight. I think that the media does indeed have a strong effect, especially on young people. Even so, everyone is exposed to the media and not everyone develops an eating

disorder. I think that there has to be another piece to the puzzle in order for the development of an eating disorder to arise. This other piece could be one or more of many things. It could be a combination of media and dieting parents. It could be a combination of media and stress. It could be a combination of media and low self-esteem and the feeling of inadequacy. It could be a combination of the media and a traumatic event. The list goes on.

This little boy, however, seems to possess some other characteristics that are common for eating disordered individuals. He has obsessive-compulsive tendencies to a high degree. Waking up at 1:30 am to get ready for school is a little earlier than normal. Avoiding friends because they are "dirty" may seem all right in some instances but not for every friend around. Tim's perfectionist nature seems to be out of control. He is obsessed with doing everything right, which is a good thing until it starts to interfere with the normality of every day life. Tim will not allow himself to take part in some of the joys of being a child such as playing with friends, eating without worrying about weight, sleeping in, and not caring about what others think. He is missing out on something that is a part of life.

This obsessive-compulsiveness has led him to this eating disorder that he faces at such a young age. In this day and age, being "perfect" or ideal includes aspects of appearance and body image. This doesn't just come from the media either. It seems that everywhere around us people are talking about losing weight or slimming down. They think that by doing this, they will ultimately be a happier person. This mentality is obviously rubbing off on children who are too young to have to feel the pressure to have what is considered by society to be the perfect body. It makes them grow up to fast.

There was no follow up mentioned about Tim, but hopefully some significant changes can be made in his behavior while he is still young.

Case #6

> Tammy was an attractive collegiate gymnast who sought treatment because she was having difficulty getting along with her coach. This difficulty was actually a side effect or complication of her bulimia. At 5'0"tall and 92 pounds, she believed that she was "close to being too big to be a gymnast." For this reason, she tried "not to eat" all day, hoping that she could then go to bed and sleep so she would not have to eat. Her bulimia reinforced her belief that she could not eat normally. On some occasions she would go without eating for 2 or 3 days. Then, however, she would become so hungry that she would begin to eat and then not be able to stop until she had eaten too much. Tammy would then tell herself that she "had blown it" and that "I might as well eat all I want because I'm going to throw it up anyway. On "bad days," as she referred to them, she might consume more than 5,000 calories throughout the day and vomit a minimum of 5 times. She believed that if she did not "get rid of the food," not only would she become "fat," but she would not be able to perform well as a gymnast. Tammy's difficulty with the coach was not the cause of her bulimia. Her coach was not even aware of her disorder. Tammy was unsure about her gymnastic ability. At the same time, she believed she had little else to offer. Her uncertainty or "fear of not being good enough" combined with her fasting-induced hunger made it virtually impossible for her to resist binge eating and purging. Her bingeing and purging often occurred just before practice. As a result, she frequently felt too sick and weak to attend practices and used this excuse to avoid them. Tammy did not realize that missing practice also protected her from confronting her fear of inadequacy as a gymnast. Her coach thought she was missing practice too frequently, even with her excuse of sickness, and began to believe that Tammy was an irresponsible malingerer. Tammy did not feel that she could tell her coach about her bulimia. As fearful as she was about her ability as a gymnast, she was even more afraid that the coach might not allow her to continue with the team. Tammy was also afraid that her coach might contact Tammy's parents, who did not know about her bulimia. (Sherman, Thompson, 1993, 84)

Discussion: When athletics are added to the story, some things change and some remain the same. Sports that are appearance based tend to produce more eating disorders than those that aren't as appearance based. These sports include figure skating, gymnastics, diving, distance running, swimming, cheerleading/dance, and bodybuilding for women and wrestling, distance running, horse racing, and bodybuilding in men (Sherman 45). Like non-athletes with eating disorders, athletes feel the pressure from society, from parents, from friends, and from themselves to strive for the ideal body. However, much added pressure comes from the sport. There are many qualities that are important in these sports – strength, speed, endurance, power, polish, and grace. The majority of these appearance-based sports depend on judges to determine the scores or

winners and the winners are the ones who "look" the best. Ideally this "look" is supposed to be based on the skill level of the performance of the athlete, but appearance often becomes an issue.

This is how Tammy's situation originated. Gymnastics places so much emphasis on the body for a couple reasons. First of all, everything that is done in gymnastics is judged based on how it looks. Body positioning is important in every skill that is done. The ideal for a gymnast is to have long lines extended and stretched throughout every routine. In this case, it is optimal to have a thin body to make the skills look the way they "should." Second, physiologically, it is a lot easier in many cases to do the skills if the body is lighter. It is much easier to swing around the bars or tumble higher in the air with a smaller body. This is why the stereotypical gymnast body is petite and lean. This is not the only thing that makes or breaks a gymnast though. A gymnast needs strength, speed, and power. These characteristics need muscle to develop. Stereotypically, a gymnast must be small and powerful – a difficult balance to achieve.

The emphasis on ideal body type sometimes gets out of control, leading to eating disorders. That is where gymnasts like Tammy run into trouble. They place so much emphasis on the appearance of their body that they end up throwing away all of the other talents they possess as a gymnast. Tammy was obviously a very talented gymnast to have competed at the collegiate level. She must have been very motivated in striving to be the best she could be in her sport. This motivation turned against her when she started to believe that she was too big to be a gymnast at a mere 92 pounds. This is a common belief for those suffering from an eating disorder. No matter how small they get, they are

never happy with their weight. They think they are "too fat" even if they are technically underweight for their height.

A characteristic of Tammy that is shared among eating disordered individuals, was that she didn't believe that she could eat normally. This all stems back to the viscous circle of fasting followed by an intense hunger, then a binge, then purging, then guilt, and then back to fasting. She *wasn't* eating normally and she was doing everything she could to try to control this, so of course she didn't believe that she could eat normally. This belief came from her intense feeling of hunger and urges to binge. She thought that that was how she, as a person, was "normally" inclined to eat. What she wouldn't let herself realize was that the reason for her overwhelming feelings of hunger was her fasting. She believed that if she ate normally, she would become fat. She did not believe that if she ate healthily and worked out as often and intensely as she did, that she would have an acceptable body. She must have felt like she needed to take control of her eating behavior and not let her body do this naturally.

Another possible reason for Tammy's behavior is the added pressure she experienced as a gymnast. There was pressure to excel in her sport coming from all around her. She must have put a lot of pressure on herself to be "perfect." There was also pressure from others such as her coach, teammates, and parents. Though she argued frequently with her coach, she most likely cared about his opinions of her as a gymnast. Collegiate gymnastics is a team oriented sport, so I'm sure she felt the pressure from her teammates to contribute to the team to her best ability. The case also mentions that she did not want her parents to find out about her disorder. This could very well mean that she values her parents' opinion of her. This is pressure that nearly every athlete is

exposed to. How different people react to pressure is different in each case. Tammy turned the pressure of being a good gymnast into pressure to be as thin as possible. Not only was this dangerous to her health, but also detrimental to her gymnastics. As her eating disorder grew stronger, her gymnastics worsened, which is the opposite of what she wanted to happen. She just got too caught up in her desire to be thin.

Case #7

> Julia grew up in a northeastern suburban town, and she's lived in the same house for her entire life. Her father is a lawyer, and her mother is the assistant principal at her town's high school. Her sister is 4 years younger than she is.
>
> Her parents, along with her whole family, get along well, however they are not particularly touchy-feely. Though their parents have busy schedules, one of them nearly always makes it to Julia's track meets and Holly's soccer games. Their mother in particular always tries to keep up with what's going on in their lives.
>
> Julia took advanced-level classes in high school and graduated in the top 10% of her class. Though she knows this made her mother proud, her mother would get worried that Julia wasn't doing her best or working to her full potential.
>
> She was always a bit "chubby" as a kid. She sometimes got teased about still having her "baby fat." Her parents wanted her to become involved in something athletic, so she started running track and cross country in middle school. It seemed to Julia to be a good way to lose weight and she gradually became one of the best runners in her high school. She got along with everyone at school but only hung out with a few close friends. She was teased when she was younger for being a goody-two-shoes. She didn't date much in high school; her parents didn't like her hanging out with boys unless in a group.
>
> Julia was awarded a full scholar athlete scholarship to the state university and felt enormous pressure to excel in both school and track. The intensity in both areas had escalated since high school. Julia gained 15 pounds in the first semester of college. This had a negative affect on her running and her coach recommended that she diet and do some extra workouts. She was very willing to diet since she wanted to lose that 15 pounds and it was quite easy for her. She dropped the 15 pounds right away then made goals for herself from there. She would analyze and reanalyze her diet to change it so that she was losing weight. She thought of hunger pains as badges of honor; symbol of her ability to control her bodily urges. The more weight she lost, the more she wanted to lose. In the end she had gone from 145 to 103. She avoided situations that were going to involve eating. Her teammates and her mother began to worry that she was too thin, but Julia argued this, as she felt happier when she was thinner. There were days when all she would consume was diet pop and coffee. (Comer, Gorenstein, 2002, 273)

Discussion: Julia is another athlete who was under pressure to succeed. She was both an excellent athlete and did extremely in school. This pressure grew more intense as she entered college and maintaining her status as a student athlete became more and more difficult for Julia. Though college life provided the final push to drive Julia to succumb

to the dangers of anorexia, there were many aspects of her childhood that set her up for what happened in college.

First of all, Julia was described as chubby. It was also mentioned that people had made fun of her for this as she was growing up. This can have a great impact on a child, especially a girl, as he or she grows up. It can lead to a poor body image, which leads to many other problems involving self-esteem and weight. This is shared occurrence among children who develop an eating disorder in their early adolescent years (First, Gibbon, Skodol, Spitzer, Williams 1994). They have been taught that their bodies aren't good enough, and have learned to dislike their bodies. They reach a point during adolescence when they feel they are sick of their body and they feel they can make a change. For some, this initiates healthy eating and exercising, but, unfortunately, for others it leads to disordered eating and low self-esteem. Though Julia didn't seem to be too affected by this, she still felt the need to change her appearance.

Julia had very involved parents. They seemed to care a great deal about being there for their children, which is an excellent way to show them that they are loved. The case especially described her mother as "always looking over Julia's shoulder" mostly involving school work. Julia sometimes felt that she wasn't doing enough to make her mom proud. It was also mentioned that the reason Julia got into running track was because her parents wanted her to do something athletic. She seemed to abide by every rule they set for her especially involving boys and curfews. She obviously quite concerned with making her parents happy and proud of her. This is an excellent quality in the majority of cases, but in some it can play a role in low self-esteem and a feeling of inadequacy.

Another commonality between Julia's case and other cases involving eating disorders is that Julia is a perfectionist. She has great grades, she is a very good track runner and she seems to always do as she is told. It doesn't seem like she has many, if any, obsessive-compulsive tendencies that are associated with her perfectionism. I think that this is one reason why she developed anorexia and didn't experience any bulimic behaviors. She seemed to have a good sense of control over all aspects of her life and if there was something that she didn't like about herself, she changed it. An example would be her running to lose weight in middle school, and her diet when her coach told her that she needed to make some changes. She did what she needed to do to make herself "happy."

Something that I found interesting about this case was the way hunger pains were described as "badges of honor." She was proud of what she was doing because it began as something positive. She had gained some weight at the beginning of college that she needed to lose to improve her running ability. Her coach gave her some tips and she was very enthusiastic about her goal of losing that 15 pounds she had gained. She ate nutritiously and exercised at first. However, when she reached her goal, she wanted to lose more. The more she lost, the more she wanted to lose. She was never happy with her body no matter how much she lost. This could be a side effect of the poor body image she developed as a child and as she was growing up, or part of her perfectionist attitude, or her need to live up to her parents' and coach's expectations (at least what she thought of as her parents' and coach's expectations).

Something else that is worth looking at is Julia's need to eat in private and her fear of gatherings that involve eating such as Thanksgiving. A lot of anorexic and

bulimic individuals feel this way because they don't want to draw attention to themselves or they don't want anyone to see how much or how little they are eating. Julia had been hearing all of the comments about how she was too thin and didn't want anyone to be around to see how little she ate. As Julia's weight was dropping, she was becoming more and more unhealthy and becoming more at risk for letting her disorder develop into a very serious problem.

Case #8

> Ms. N., a 26-year-old single woman who was pursuing college studies and part-time employment, presented to us for treatment of anorexia nervosa and depression. At age 15, in response to weight preoccupations, the patient began vomiting, diuretics, and laxative abuse. She had multiple hospitalizations for suicidality. Prior to hospitalization with us the patient restricted down to 97.5 pounds with 3 months of amenorrhea. When asked to explain this behavior, Ms. N. stated her goal was to be less than 89 pounds and thereby die.
>
> In addition to the anorexic behavior, the patient regularly self-mutilated with razor blades "to feel better" and episodically abused alcohol. Trials of lithium, antidepressants, and minor tranquilizers had been unsuccessful.
>
> At admission, the patient was alternately defiant, docile, or preoccupied, frequently appearing blank. Mood was depressed, and affect incongruent with content. She was guarded and circumstantial with some loosening of association. The patient also described periods of lost time, amnesia, and the "presence of 2 or 3 different parts of me" experienced as internal voices. Ms. N. wished to die by starvation and admitted to impulses to hurt herself. Admitting diagnoses were major depressive disorder, anorexia nervosa, bulimia nervosa, and MPD, provisional.
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> At the start of the patient's 6-week hospitalization she was placed on perphenazine up to 16 mg at bedtime to decrease her guarded and suspicious attitude. By the second week a mute alter who expressed depression and urges toward self-destruction behavior emerged followed by a docile, childish alter. The patient indicated the presence of several other alters but these did not emerge directly in the hospital. Despite these clear signs, the patient rejected the label of MPD, only acknowledging dissociation and the presence of distinct parts to herself.
>
> Increased communication between alters and with the staff increased control of self-destructive impulses. The patient gained weight consistently over her stay, reaching 118 pounds in 4 weeks. She frequently requested extra food and actively sought out nutritional counseling. Ms. N. linked her starvation behavior to a wish to die by several of her alters. At discharge, although the patient recognized she was still vulnerable to urges to starve or hurt herself, she felt "the part of me that wants to live is stronger." (Kahan, Laam, Levin, Spauster, 1993, 236).

Discussion: This case was interesting to me because it presents an alternate cause of an eating disorder(s). Most other cases deal with the individual's struggle to mold their body into the ideal. These cases have dealt with body image distortion and the desire to be thin based on the belief that this would bring about happiness. It was all about

appearance and look. Ms. N. did not appear to have any concern for what others though of her or about her appearance. She just wanted to die. She wanted to starve herself to death because she was that unhappy with her life. Anorexia by definition means "loss of appetite" and, because of her other motives, Ms. N. clearly did not have the appetite that a normal person has. Though this is not an image problem like other cases, it does have a lot to do with self-esteem, which is a problem in the vast majority of eating disorder cases. Ms. N. had a low self-esteem that caused her many problems including her eating disorder. For one thing she was suicidal, which is something that is fairly common. She was so depressed about her life that she felt that the best way out was by killing herself. She must have felt hopeless about any type of recovery she could work on. It seems like when she was at this stage, however, she was not "mentally available" enough to believe that her life could get better. This seems like another one-way mind set that can be seen in many eating disorder cases. She thought she knew what she wanted and she was going to do anything to get that – even if it meant starving herself. And like many other cases, she was very good at what she was doing to herself. It's too bad that this drive and motivation that she possessed was so negative. Again, someone with so much motivation that such great pain can be endured, would be an amazing person if his or her motivation was headed in amore positive direction.

A commonality between this case and others is the presence of mental illness other than just the eating disorder itself. First of all, Ms. N. was depressed. Not much is mentioned at all about the cause of this. It could have been anything from a traumatic event in her life to a chemical imbalance that she was genetically destined to have. At any rate, she didn't feel good about her life. Her self-esteem was low and it seemed that

she didn't think she had much to live for. She stated bluntly that she didn't want to eat so that she would starve and die. This is a different motivation for starvation than most other eating disorder cases because she does not have the desire to be thin. She has the desire to die. Though the actions of the individual are similar, the cases themselves are quite different. Because of the refusal to eat, Ms. N. was diagnosed with the same illness as someone who is an overachiever, very popular with her friends, athletic, and has a desperate desire to be beautiful – anorexia nervosa. Ms. N. however, was diagnosed with other illnesses as well as her eating disorder.

Another commonality between Ms. N. and some other cases was her self-mutilating behaviors. She purposefully inflicted pain and anguish upon herself that others could never imagine. This was a part of her personality at that time of her life. She wanted to do what she was doing, perhaps because she was so unhappy. What I thought was interesting was that she carried out these behaviors "to make herself feel better." This seems like such a confused outlook, but a deeper look into the situation could demonstrate some method to her madness. One explanation that I could think of was that possibility that this was a stress reliever for her. She obviously hated her life if she wanted to end it so badly. It didn't seem like she was blaming her problems on anyone or anything in particular; at least nothing that was mentioned in the case. She may have blamed herself for her condition, which caused the self-hatred that was strong enough to lead to her intense suicidal feelings. She may have felt an unconscious need to punish herself. This punishment was carried out by self-harm, which, although it caused her a great deal of pain, it may have relieved the "stress" or need she was feeling to punish herself for her problems in life. It seems twisted, but I have looked at other cases

that have been similar in this way. She relieved her pain through a different type of pain. The explanation of Ms. N's multiple personalities was interesting to me as well. I think what I took not of the most was that only when these separate alters were brought out into the open could the recovery process begin for Ms. N. I'm not sure how to analyze this. One parallel to this would be that oftentimes individuals with eating disorders have a much easier time dealing with their problems if they simply talk about them. Keeping things bottled up inside is never healthy in any circumstance.

Talking about any problems is commonly the easiest way to solve them. Ms. N., by getting her separate personalities out into the open could more easily work on her recovery. I thought her quote at the end of the case could be inspirational for anyone who is struggling with suicidal behaviors – "the part of me that wants to live is stronger."

In conclusion of this paper, I would like to point out some major similarities and differences that I have noticed between cases. I have noticed that all of these individuals have shared many of the same traits and characteristics. The 3 that were the most noticeable to me were obsessive-compulsive behavior, low self-esteem, and some type of a "spark" that induced or increased the eating disorder. For the majority of the cases, there was obsessive-compulsive behavior. This ranged from moderate to severe as in eight-year-old Tim's story. This seems to be a commonality and I think that it is something that sets the people with eating disorders apart from those eat relatively normally. Very many people want to have unattainable thin little bodies, but only some people get caught up enough with this obsession to develop a disorder.

Another aspect that was noticeable in the majority of the cases was a low self-esteem. This is the fuel for many eating disordered individuals because their sense of

self-worth is so poor that they think that they need to focus on their appearance to be accepted in society. Although their styles of disordered eating were quite different, Nancy and Abby were similar in this way. They both cared a great deal about how they were viewed by others. Ms. N had the same problem with self-esteem as these 2 women did, but her case was different in that she didn't care what others thought – she just had such a low sense of self-worth that she wanted to die. This then developed into an eating disorder similar to Julia's in that she just refused to feed herself.

Most of the individuals had experienced some kind of "spark" that either set off their disorder or intensified it. In Ms. C's case, it was the rape, in Nadia's case it was her mom's death, in Abby's relapse it was the emotional event of the wedding, and in Julia's case it was the comments from her coach. If the mentality is already there, it only takes a "spark" to light the fire. All of these girls possessed the characteristics that give rise to eating disorders, and, most likely, the spark could have been a number of different things. The spark is not to blame because everyone experiences rough times in their lives. It was just something that pushed these women over the threshold as far as their eating was concerned.

I can gladly say that I have learned a lot from this project. It has been very interesting to me to look at all of the different cases and get a feel for how different people deal with their eating disorders. Some people were so different, yet some were so much the same. I felt that I could relate to many cases in one way or another. I know enough about the pain that an eating disorder causes to be sympathetic to every individual of every case that I read. It is a very difficult problem to deal with at any level. It drains the body both physically and emotionally. Reading some of these cases made me so sad

because I looked at the individuals involved and how this horrible illness has destructively and aggressively ruined their lives. It has stolen so many lives in one way or another either literally or figuratively. What is worse is that this disorder is so unnecessary. People who are not as thin as a rail are still loved. People who are not as thin as a rail are still successful. People who are not as thin as a rail are still happy. This realization is often not easy to come to, and for many people who struggle with eating disorders, it's not a realization that they even want to come to.

I have learned more about myself through completing this project. In some ways it has helped me to put things in perspective in my life. I have looked at what these people have done to their lives and it made me realize more and more that letting something like an eating disorder take control of my life is just not worth it. I have so much to be thankful for, so much to be proud of, and so much to look forward to in my life. That is something that I have to keep reminding myself and is something that I would recommend for anyone in the same situation. Everyone is unique in their own way and has so much to offer if they let themselves realize it. Any distraction that gets in the way of this is just not worth it.

References

Comer, R. J., Gorenstein, E. E. (Eds) (2002). Case Studies in Abnormal Psychology. New York, NY: Worth Publishers.

Fergusen, J. M. 1993. The Use of Electroconvulsive Therapy in Patients with Intractable Anorexia Nervosa. International Journal of Eating Disorders,, 13(2), 195-201.

First, M. B., Gibbon, M., Skodol, A. E., Spitzer, R. L., Williams, J. B. W. (Eds) (1994). DSM-IV Case Book: A learning companion to the Diagnostic and Statistical Manual of Mental Disorders – fourth edition. Washington, CD: American Psychiatric Press.

Hudson, J. I., Mialet, J., Pope Jr., H. G. 1985. Bulimia in the late nineteenth century: the Observations of Pierre Janet. Psychological Medicine, 15, 739-743.

Kahan, M., Laam, J. B., Levin, A. P., Spauster, E. 1993. Multiple Personality in Eating Disorder Patients. International Journal of Eating Disorders, 13(2), 235-238.

Kilbourne, J. 1994. Still Killing Us Softly: Advertising and the Obsession with Thinness. In Fallon, P., Katzman, M. A., Wooley, S. C. (Eds) Feminist Perspectives on Eating Disorders. New York: Guilford Press.

Lieberman, S., M.D. 1989. A Family with Four Bulimic Children. International Journal of Eating Disorders. 8(1), 101-104.

Rodin, J., Silberstein, L. R., Striegel-Moore, R. H. 1986. Toward an Understanding of Risk Factors for Bulimia. American Psychologist, 41, 246-258.

Sherman, R. T., Thompson, R. A. (Eds) (1993). Helping Athletes with Eating Disorders. Champaign, IL: Human Kinetics Publishers.

Striegel-Moore, R. H., Smolau, L. (Eds) (2001). Eating Disorders: Innovative Directions in Research and Practice. Washington, DC: American Psychological Association.

What is Trance? (July 2002) Online. Available: www.deep-trance.com/articles/definitions/ whatistrance.html